COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

October 1, 2010

Tom Moss, Administrator
Preferred Community Homes - Cornerstone
615 2nd Avenue West
Wendell, ID 83355

Provider #13G056

Dear Mr. Moss:

On **September 16, 2010**, a complaint survey was conducted at Preferred Community Homes - Cornerstone. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004709

Allegation #1: Individuals are not receiving active treatment, including physical therapy exercises, due to insufficient numbers of staff.

Finding #1: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations, record review, and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator reported to the survey team there were 7 individuals residing in the facility, and 4 direct care staff were required on the morning and evening shifts to meet the needs of the individuals.

Observations were conducted for a cumulative 5 hours across the morning and evening shifts. During that time, 4 direct care staff were noted to be working those shifts, and individuals were noted to receive both formal and informal training as identified in their IPPs (Individual Program Plans). Additionally, 4 individuals were selected for review. The individuals' records documented ongoing program

implementation at the assigned rates.

Further, 8 direct care staff were interviewed. All staff stated they were able to meet the needs of the individuals with the current staffing levels.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff use inappropriate language and administration does nothing.

Finding #2: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, investigation reports, observations, and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator stated he had assumed administrative duties at the facility on 7/27/10. Since his arrival, 18 separate investigations of alleged abuse, neglect, and mistreatment had been completed. As a result of those investigations, the previous Administrator and several staff were released from employment.

Review of those investigations showed a staff was alleged to have used inappropriate language towards individuals residing at the facility. The investigation found the allegation to be substantiated and that staff was released from employment.

Observations were conducted for a cumulative 5 hours across the morning and evening shifts. During that time, staff were not observed to use inappropriate language with individuals.

Additionally, 8 direct care staff were interviewed. None of the staff reported inappropriate language being used with the individuals.

Therefore, the allegation was substantiated. However, the facility investigated the incident and took appropriate corrective action and no deficient practice was identified.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm

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October 1, 2010

Tom Moss, Administrator
Preferred Community Homes - Cornerstone
615 2nd Avenue West
Wendell, ID 83355

Provider #13G056

Dear . Carpenter:

On **September 16, 2010**, a complaint survey was conducted at Preferred Community Homes - Cornerstone. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004712

Allegation #1: The facility has insufficient staff to meet the needs of the individuals.

Finding #1: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations, record review, and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator reported to the survey team there were 7 individuals residing in the facility, and 4 direct care staff were required on the morning and evening shifts to meet the needs of the individuals.

Observations were conducted for a cumulative 5 hours across the morning and evening shifts. During that time, 4 direct care staff were noted to be working those shifts, and individuals were noted to receive both formal and informal training as identified in their IPPs (Individual Program Plans). Additionally, 4 individuals were selected for review. The individuals' records documented ongoing program implementation at the assigned rates.

Further, 8 direct care staff were interviewed. All staff stated they were able to meet the needs of the individuals with the current staffing levels.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals are not adequately supervised on community outings.

Finding #2: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, investigation reports, observations, and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator stated he had assumed administrative duties at the facility on 7/27/10. Since his arrival, 18 separate investigations of alleged abuse, neglect, and mistreatment had been completed. As a result of those investigations, the previous Administrator and several staff were released from employment.

Review of those investigations showed an allegation had been made that staff had left 4 individuals in a van with one staff member to monitor while 2 other staff members visited a flea market. The investigation found the allegation to be substantiated and staff were re-trained on appropriate supervision and community outings.

Observations were conducted for a cumulative 5 hours across the morning and evening shifts. During that time, staff were observed to provide appropriate supervision to the individuals residing in the facility.

Additionally, 8 direct care staff were interviewed. All staff reported that they had additional training and clarification on appropriate supervision and community outings since the new administrator arrived.

Therefore, the allegation was substantiated. However, the facility investigated the incident and took appropriate corrective action and no deficient practice was identified.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm

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October 1, 2010

Tom Moss, Administrator
Preferred Community Homes - Cornerstone
615 2nd Avenue West
Wendell, ID 83355

RE: Preferred Community Homes - Cornerstone, Provider #13G056

Dear Mr. Moss:

This is to advise you of the findings of the complaint survey of Preferred Community Homes - Cornerstone, which was conducted on September 16, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when

preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **October 13, 2010**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by October 13, 2010. If a request for informal dispute resolution is received after October 13, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm
Enclosures

IDAHO DEPARTMENT OF
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C.L. "BUTCH" OTTER – Governor
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October 1, 2010

Tom Moss, Administrator
Preferred Community Homes - Cornerstone
615 2nd Avenue West
Wendell, ID 83355

Provider #13G056

Dear Mr. Moss:

On **September 16, 2010**, a complaint survey was conducted at Preferred Community Homes - Cornerstone. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004749

Allegation #1: An individual's medical needs are not being adequately addressed.

Finding #1: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, incident/accident reports, observations, record review, and staff interviews were completed with the following results:

The facility's incident/accident reports from 7/1/10 - 9/13/10 were reviewed. None of the incident/accident reports documented concerns with individuals' medical needs.

An environmental review was conducted at the facility on 9/14/10 from 1:05 - 1:30 p.m. During that time, a high-seated hard-back chair was noted to be in the living room. When asked, present staff reported the chair was preferred by an individual who would not sit on her bottom. The staff stated the individual would not tolerate sitting in the recliner or on the couch. The staff reported they were informed the individual was examined by her doctor who stated there was nothing medically wrong; it was behavioral. When asked, the AQMRP (Assistant Qualified Mental Retardation Professional), who was present, stated the individual's sitting behavior

was not being tracked as an unusual or odd behavior.

During an observation on 9/14/10 from 5:00 - 6:25 p.m., the individual was noted to be seated at the dining table. She was leaning to the right side such that her right hand was positioned on the seat of the chair and her left buttock was not touching the seat. When asked, present staff stated the individual would not sit flat with both buttocks on the chair. The staff reported that given time, the individual would lean back and "slide" down to where she was sitting on her sacral (the large triangular bone at the base of the spine) area and eventually turn and position herself so that she was bent over the chair with both knees on the floor and her upper body resting on the seat of the chair. When the individual was finished eating, she was prompted to take her dishes to the sink, which she did. It was noted that once at the sink, she grasped the edges of the sink with both hands and lifted her left foot from the floor. The LPN (Licensed Practical Nurse) was present. When asked, the LPN stated the individual was examined on 9/2/10 and nothing was found to be medically wrong; it was behavioral.

Four individuals were selected for review. One individual's record showed she periodically scratched at the back of her neck and medicated ointment was prescribed. The individual's record also documented intermittent episodes of pain with periodic use of Ibuprofen (an anti-inflammatory drug). The individual's record did not contain a pain assessment and the sitting behavior was not identified in the individual's comprehensive functional assessment.

Therefore, the allegation was substantiated and the facility was cited at W259 and W322.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: An individual is not allowed to sit on specific pieces of living room furniture.

Finding #2: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations, record review, and staff interviews were completed with the following results:

An environmental review was conducted at the facility on 9/14/10 from 1:05 - 1:30 p.m. During that time, a high-seated hard-back chair was noted to be in the living room. When asked, present staff reported the chair was preferred by an individual who would not sit on her bottom. The staff stated the individual would not tolerate sitting in the recliner or on the couch.

Observations were conducted on 9/14/10 for a cumulative 5 hours. During that time, individuals were not observed to be restricted from sitting on living room furniture. However, during an observation on 9/14/10 from 5:00 - 6:25 p.m., an individual was noted to be seated at the dining table. The individual was sitting in an odd fashion in that she would not sit flat on her bottom, but leaned to the right side keeping her left buttocks off the chair. When asked, present staff stated the individual was offered different sitting locations, including the couch, the recliner, the high-seated chair, or a dining room chair. The staff stated the individual would refuse to sit on the couch or the recliner.

Four individuals were selected for review. None of the records documented restrictions related to where individuals were allowed to sit.

When asked during an interview on 9/15/10 at 2:55 p.m., the RSC stated there were no restrictions related to where individuals could sit in the facility.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Individuals who require one-to-one supervision are not one-to-one due to insufficient staff.

Finding #3: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations, record review, and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator reported to the survey team there were 7 individuals residing in the facility, and 4 direct care staff were required on the morning and evening shifts to meet the needs of the individuals. The Administrator stated no individuals in the facility required one-to-one supervision.

Observations were conducted for a cumulative 5 across the morning and evening shifts. During that time, 4 direct care staff were noted to be working each of those shifts, and individuals were noted to receive both formal and informal training as identified in their IPPs (Individual Program Plans). No individuals in the facility were noted to require one-to-one supervision.

Additionally, 4 individuals were selected for review. The individuals' records documented ongoing program implementation at the assigned rates and none of the records documented a need for one-to-one supervision.

Further, 8 direct care staff were interviewed. All staff stated they were able to meet the needs of the individuals with the current staffing levels.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Staff are taking individuals' personal possessions for their own use and the RSC does nothing about it.

Finding #4: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, incident/accident reports, observations, record review, and staff interviews were completed with the following results:

The facility's Incident/Accident Reports, dated 7/1/10 - 9/13/10, were reviewed. None of the Incident/Accident Reports documented concerns with staff taking individuals' personal possessions for their own use.

During observations on 9/14/10 for a cumulative 5 hours, eight (8) direct care staff were interviewed. None of the staff reported that individuals' personal possessions were missing.

However, five (5) individuals' Personal Inventory forms documented full inventories had not been completed since 5/11/09. Additional Personal Inventory forms for the five individuals showed various clothing items had been added and discarded since the full inventories were completed. Further, one individual did not have a Personal Inventory and one individual's Personal Inventory form did not contain information related to personal clothing.

The RSC (Residential Service Coordinator) stated during an interview on 9/15/10 from 6:20 - 6:50 p.m., staff would bag individuals' worn or torn clothing for disposal or storage, and at that time, staff were to complete an additional Personal Inventory form to document the discarded items. The RSC stated no one verified what items had been removed by staff. When asked, the RSC stated it would not currently be

possible to ensure staff were not taking individuals' belongings for their own use. The Administrator, who was present during the interview, stated the RSC was responsible for ensuring Personal Inventory forms were completed quarterly. When asked, the Administrator stated the facility would be unable to ensure individuals' belongings were accounted for and secured with the current implementation of the system.

Therefore, the allegation was unsubstantiated. However, deficient practice was identified and the facility was cited at W137.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Individuals do not have appropriate or sufficient clothing for school.

Finding #5: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations and staff interviews were completed with the following results:

An environmental review was conducted at the facility on 9/14/10 from 1:05 - 1:30 p.m. During that time, the survey team noted that all individuals' bedroom closets and dressers contained an abundance of clothing items. The clothing items were noted to be clean and in good condition.

Observations were conducted on 9/14/10 for a cumulative 5 hours. During that time, individuals were noted to be dressed appropriately and well groomed.

Eight direct care staff were interviewed during the course of the survey. None of the staff reported concerns with individuals' clothing or appearance.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: The facilities dishwasher and clothing washer are broken and staff are required to use personal vehicles to complete laundry tasks.

Finding #6: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations and staff interviews were completed with the following results:

An environmental review was conducted at the facility on 9/14/10 from 1:05 - 1:30 p.m. During that time, it was noted there were two dishwashers in the kitchen. Both dishwashers were in operation. The survey team noted a large basket of soiled clothing in the laundry room. Present staff reported the washing machine was broken and the repairman was waiting for a needed part that was on order. When asked, the staff reported they delivered the soiled laundry to a nearby facility, owned and operated by the same company. The staff reported that after the clothing items were washed, they were then returned to the facility to be dried and folded.

Observations were conducted on 9/14/10 for a cumulative 5 hours. During that time, a staff person was noted to place the large basket of soiled clothing in the facility's van. When asked, the staff person reported he was taking the items to the nearby facility for washing.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Michael A Case, LSW

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm

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October 1, 2010

Tom Moss, Administrator
Preferred Community Homes - Cornerstone
615 2nd Avenue West
Wendell, ID 83355

Provider #13G056

Dear . Carpenter:

On **September 16, 2010**, a complaint survey was conducted at Preferred Community Homes - Cornerstone. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004712

Allegation #1: The facility has insufficient staff to meet the needs of the individuals.

Finding #1: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations, record review, and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator reported to the survey team there were 7 individuals residing in the facility, and 4 direct care staff were required on the morning and evening shifts to meet the needs of the individuals.

Observations were conducted for a cumulative 5 hours across the morning and evening shifts. During that time, 4 direct care staff were noted to be working those shifts, and individuals were noted to receive both formal and informal training as identified in their IPPs (Individual Program Plans). Additionally, 4 individuals were selected for review. The individuals' records documented ongoing program implementation at the assigned rates.

Further, 8 direct care staff were interviewed. All staff stated they were able to meet the needs of the individuals with the current staffing levels.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals are not adequately supervised on community outings.

Finding #2: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, investigation reports, observations, and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator stated he had assumed administrative duties at the facility on 7/27/10. Since his arrival, 18 separate investigations of alleged abuse, neglect, and mistreatment had been completed. As a result of those investigations, the previous Administrator and several staff were released from employment.

Review of those investigations showed an allegation had been made that staff had left 4 individuals in a van with one staff member to monitor while 2 other staff members visited a flea market. The investigation found the allegation to be substantiated and staff were re-trained on appropriate supervision and community outings.

Observations were conducted for a cumulative 5 hours across the morning and evening shifts. During that time, staff were observed to provide appropriate supervision to the individuals residing in the facility.

Additionally, 8 direct care staff were interviewed. All staff reported that they had additional training and clarification on appropriate supervision and community outings since the new administrator arrived.

Therefore, the allegation was substantiated. However, the facility investigated the incident and took appropriate corrective action and no deficient practice was identified.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

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Preferred Community Homes - Cornerstone
615 2nd Avenue West
Wendell, ID 83355

Provider #13G056

Dear Mr. Moss:

On **September 16, 2010**, a complaint survey was conducted at Preferred Community Homes - Cornerstone. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004709

Allegation #1: Individuals are not receiving active treatment, including physical therapy exercises, due to insufficient numbers of staff.

Finding #1: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations, record review, and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator reported to the survey team there were 7 individuals residing in the facility, and 4 direct care staff were required on the morning and evening shifts to meet the needs of the individuals.

Observations were conducted for a cumulative 5 hours across the morning and evening shifts. During that time, 4 direct care staff were noted to be working those shifts, and individuals were noted to receive both formal and informal training as identified in their IPPs (Individual Program Plans). Additionally, 4 individuals were selected for review. The individuals' records documented ongoing program

implementation at the assigned rates.

Further, 8 direct care staff were interviewed. All staff stated they were able to meet the needs of the individuals with the current staffing levels.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff use inappropriate language and administration does nothing.

Finding #2: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, investigation reports, observations, and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator stated he had assumed administrative duties at the facility on 7/27/10. Since his arrival, 18 separate investigations of alleged abuse, neglect, and mistreatment had been completed. As a result of those investigations, the previous Administrator and several staff were released from employment.

Review of those investigations showed a staff was alleged to have used inappropriate language towards individuals residing at the facility. The investigation found the allegation to be substantiated and that staff was released from employment.

Observations were conducted for a cumulative 5 hours across the morning and evening shifts. During that time, staff were not observed to use inappropriate language with individuals.

Additionally, 8 direct care staff were interviewed. None of the staff reported inappropriate language being used with the individuals.

Therefore, the allegation was substantiated. However, the facility investigated the incident and took appropriate corrective action and no deficient practice was identified.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING ______ B. WING ______	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Leader Monica Nielsen, QMRP Common abbreviations/symbols used in this report are: AQMRP - Assistant Qualified Mental Retardation Professional BID - Twice daily CT - Computerized Axial Tomography Scan IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record OSHA - Occupational Safety Health Association PRN - As needed QMRP - Qualified Mental Retardation Professional RN - Registered Nurse RSC - Residential Service Coordinator TID - Three times daily	W 000	**W 000 INITIAL COMMENTS** "Preparation and implementation of this plan of correction does not constitute admission or agreement by Cornerstone with the facts, findings or other statements as alleged by the state agency dated September 16, 2010. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Cornerstone – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action." RECEIVED OCT 20 2010 FACILITY STANDARDS	
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure sufficient systems had been developed and implemented to ensure individuals' personal	W 137	**W 137 483.420(a)(12) PROTECTION OF CLIENTS RIGHTS** The home supervisor will be provided with additional training in regards to assuring that client personal possessions are accurately accounted for and kept secure. A new Administrator/QMRP has been hired and assigned to work at the Cornerstone Facility. Her first day was	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Moss | TITLE: Administrator | (X6) DATE: 10/18/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 137	Continued From page 1 possessions were accounted for and secured for 7 of 7 individuals (Individuals #1 - #7) whose Personal Inventories were reviewed. This resulted in the potential for individuals' possessions to be lost, stolen, or destroyed without appropriate interventions being implemented. The findings include: Individuals #1 - #7s' Personal Inventory forms were reviewed on 9/15/10. The forms stated "A full inventory needs to be done in March, May, September and December for every client." However, when asked about the forms, the RSC stated during an interview on 9/15/10 from 6:20 - 6:50 p.m., she did not know how frequently the forms were to be completed A review of the forms documented full inventories had not been completed since 5/11/09 for Individuals #1, #2, #3, #4, and #6. No Personal Inventory could be located for Individual #5. Individual #7's inventory did not document his clothing. Additional Personal Inventory forms for Individuals #1 - #4, and #6 were reviewed and showed various clothing items had been added and discarded since the full inventories were completed. However, there was no documentation of what happened to discarded items. When asked during an interview on 9/15/10 from 6:20 - 6:50 p.m., the RSC stated staff would bag individuals' worn or torn clothing for disposal or storage, and at that time, staff were to complete an additional Personal Inventory form to document the items removed. The RSC stated	W 137	10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that personal possessions are accurately accounted for and kept secure. The Assistant to the Regional Administrator has been assigned to provide supervision to the Cornerstone ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations in maintained. One part of the Quality Assurance measures includes reviewing that personal possessions are inventoried and kept safe. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures. **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/31/10	

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	13G056	A. BUILDING _____ B. WING _____	C 09/16/2010

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W 137	Continued From page 2 no one verified what items had been removed by staff. When asked, the RSC stated it would not currently be possible to ensure staff were not taking individuals' belongings for their own use. The Administrator, who was present during the interview, stated the RSC was responsible for ensuring Personal Inventory forms were completed quarterly. When asked, the Administrator stated the facility would be unable to ensure individuals' belongings were accounted for and secured with the current implementation of the system. The facility failed to ensure individuals' personal possessions were accurately accounted for and kept secure.	W 137		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination which directly impacted 4 of 4 individuals (Individuals #1 - #4) reviewed, and had the potential to impact 7 of 7 individuals (Individuals #1 - #7) residing in the facility. That failure resulted in individuals not receiving the necessary assessments, training, and monitoring required to meet their behavioral needs. The findings include: 1. Refer to W137 as it relates to the facility's failure to ensure the QMRP ensured individuals'	W 159	**W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL** Please refer the plans of correction given for W137, W207, W259 and W322. **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/31/10	

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W 159	Continued From page 3 personal possessions were accounted for. 2. Refer to W207 as it relates to the facility's failure to ensure the QMRP ensured appropriate facility staff participated in interdisciplinary team meetings. 3. Refer to W259 as it relates to the facility's failure to ensure the QMRP ensured an individual's comprehensive functional assessment was reviewed for relevancy and updated as necessary. 4. Refer to W322 as it relates to the facility's failure to ensure the QMRP ensured an individual received general and preventive medical care.	W 159		
W 207	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Appropriate facility staff must participate in interdisciplinary team meetings. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure appropriate facility staff participated in the IDT meetings for 4 of 4 individuals (Individuals #1 - #4) whose IPPs were reviewed. This resulted in the potential for a lack of comprehensive information being provided in the development of IPPs and a lack of opportunities for the IDT members to consult with one another and to exchange information. The findings include: 1. Individual #4's 3/9/10 IPP stated he was a 35 year old male whose diagnoses included profound psychomotor retardation, kyphoscoliosis, quadriplegia with profound flexion contractures of both upper and lower extremities,	W 207	**W 207 483.440(c)(2) INDIVIDUAL PROGRAM PLAN** Preferred Community Homes held IPP meetings for three of the individuals on 9/29/10. An experienced QMRP was sent to the home to coordinate the IPP meetings. The Administrator verified that the LPN and a direct care staff participated in the IPP meetings as well as outside professionals. At the time of the meetings the AQMRP received training in regards to the importance of having appropriate staff attend the meetings. A new Administrator/QMRP has been hired and assigned to work at the Cornerstone Facility. Her first day was 10/13/10. The new Administrator will receive training from current Administrative staff including the	

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W 207	Continued From page 4 history of bilateral hip dislocation, cortical blindness, hearing impairment, and osteopenia. His IPP showed his father (via phone), the QMRP, and one direct care staff attended his IPP. There was no evidence other direct care staff or nursing personnel were encouraged to participate in the meeting. When asked about the attendance of direct care staff, the Administrator stated during an interview on 9/16/10 from 1:05 - 1:50 p.m., that the problem was identified about six months ago when the parent company conducted a quality assurance survey. 2. Individual #3's 3/12/10 IPP stated he was a 34 year old male whose diagnoses included profound psychomotor retardation, spastic quadriparesis, intrathecal baclofen pump, dislocated left hip, cortical blindness, and osteopenia. His IPP showed the Administrator, the QMRP, the AQMRP, and the Physical Therapist attended his IPP. There was no evidence that direct care staff or nursing personnel were encouraged to participate in the meeting. When asked about the attendance of direct care staff, the Administrator stated during an interview on 9/16/10 from 1:05 - 1:50 p.m., that the problem was identified about six months ago when the parent company conducted a quality assurance survey.	W 207	**importance of assuring that adequate staff participates in the IPP meetings.** **The Assistant to the Regional Administrator has been assigned to provide supervision to the Cornerstone ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes reviewing the IPP's to assure that adequate staff participates in the meetings. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/31/10	

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W 207	Continued From page 5 3. Individual #1's IPP, dated 5/27/10, Individual #1's IPP, dated 5/27/10, documented an 18 year old female diagnosed with profound mental retardation, blindness, and hydrocephalus with a ventriculoperitoneal shunt (a surgery performed to relieve intracranial [inside the skull] pressure caused by hydrocephalus [water on the brain]). Her IPP showed her parents (via phone), the Administrator, the QMRP, and the AQMRP attended her IPP. There was no evidence that direct care staff or nursing personnel were encouraged to participate in the meeting. When asked about the attendance of direct care staff, the Administrator stated during an interview on 9/16/10 from 12:50 - 1:05 p.m., that problem was identified about six months ago when the parent company conducted a quality assurance survey. 4. Individual #2's IPP, dated 3/12/10, documented a 35 year old female diagnosed with profound mental retardation, seizure disorder, anorexia, osteopenia, and hydrocephalus with a ventriculoperitoneal shunt (a surgery performed to relieve intracranial [inside the skull] pressure caused by hydrocephalus [water on the brain]). Her IPP showed her mother (via phone), the Administrator, the QMRP, the AQMRP, RSC, and LPN attended her IPP. There was no evidence that direct care staff were encouraged to participate in the meeting.	W 207		

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W 207	Continued From page 6 When asked about the attendance of direct care staff, the Administrator stated during an interview on 9/16/10 from 12:50 - 1:05 p.m., that problem was identified about six months ago when the parent company conducted a quality assurance survey. The facility failed to ensure facility staff were encouraged to attend and participate in the IPP meetings for Individuals #1 - #4.	W 207		
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure the comprehensive functional assessment was reviewed by the interdisciplinary team for relevancy and updated as necessary for 1 of 4 individuals (Individual #1) whose records were reviewed. This resulted in an individual exhibiting unusual sitting behavior without an assessment as to the reason. The findings include: 1. Individual #1's IPP, dated 5/27/10, documented an 18 year old female diagnosed with profound mental retardation, blindness, hydrocephalus with a ventriculoperitoneal shunt (a surgery performed to relieve intracranial [inside the skull] pressure caused by hydrocephalus [water on the brain]), heavy menses with extreme cramps, and constipation. Individual #1 was non-verbal and had limited expressive communication skills.	W 259	**W 259 483.440(f)(2) PROGRAM MONITORING & CHANGE** Preferred Community Homes has begun collecting baseline data. The AQMRP has given the staff a formal instruction and the staff is collecting this data on an ABC data sheet per the facility policy and procedure. The AQMRP has received additional training in regards to the behavior support policy. In addition to this the RN and LPN are continuing to work with individual #1's doctors to rule out possible medical causes of her behavior. A new Administrator/QMRP has been hired and assigned to work at the Cornerstone Facility. Her first day was 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of reviewing the comprehensive functional assessment and updating it as needed. The Assistant to the Regional Administrator has been assigned to	

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W 259	Continued From page 7 a. An observation was conducted at the facility on 9/14/10 from 5:00 - 6:25 p.m. During that time, Individual #1 was noted to be seated at the dining table. She was leaning to the right side such that her right hand was positioned on the seat of the chair and her left buttock was not touching the seat. When asked, present staff stated that Individual #1 would not sit flat with both buttocks on the chair. The staff reported that given time, Individual #1 would lean back and "slide" down to where she was sitting on her sacral area (the large triangular bone at the base of the spine) and eventually turn and position herself so that she was bent over the chair with both knees on the floor and her upper body resting on the seat of the chair. When Individual #1 was finished eating, she was prompted to take her dishes to the sink, which she did. It was noted that once at the sink, she grasped the edges of the sink with both hands and lifted her left foot from the floor. Further, a second staff stated that Individual #1 used to sit on a mat on the living room floor but now she would not sit; she would lay on her right side in a fetal position. When asked, the staff reported this had been going on for "awhile" and stated they were told Individual #1 saw a doctor and that nothing was wrong; it was behavioral. Additionally, during an observation on 9/14/10 from 1:05 - 2:15 p.m., a staff stated when Individual #1 sat in the overstuffed recliner or on the couch, she would have a "behavior." The staff reported that Individual #1 preferred a chair with a solid seat and would not sit on her buttocks very well. The staff reported that Individual #1 would not sit straight but chose to sit on her sacral (the large triangular bone at the base of the spine) area. The AQMRP, who was present,	W 259	provide supervision to the Cornerstone ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes reviewing the comprehensive functional assessment and updating it as needed. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures. **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/31/10	

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W 259	Continued From page 8 stated the sitting behavior was not being documented or tracked. The facility failed to consistently document and track Individual #1's unwillingness and/or refusal to sit flat on her bottom. b. Individual #1's record documented difficulty and/or an unwillingness to sit flat on her bottom in 11/09. Individual #1 was assessed for possible hemorrhoids in that month, and were ruled out as a possible cause. No additional assessment of the issue could be found in Individual #1's record. However, Individual #1's record documented a reoccurrence of the sitting behavior in 9/10. She was examined by the Nurse Practitioner on 9/2/10, who documented no skin lesions were found. No additional assessment of the issue could be found in Individual #1's record. The LPN and RN were present during the observation on 9/14/10 from 5:00 - 6:25 p.m. When asked, the LPN stated Individual #1 was examined on 9/2/10 and nothing was wrong; it was behavioral. The survey team met with the Administrator, contract RN, the RN from the parent company, and the AQMRP on 9/15/10 at 5:50 p.m. The AQMRP reported she just developed a tracking sheet related to Individual #1's not wanting to sit or bear weight. When asked, the AQMRP stated no prior tracking system had been developed. The AQMRP stated no additional assessment had been completed. The facility failed to ensure Individual #1's reoccurring refusal and/or unwillingness to sit flat	W 259		

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W 259	Continued From page 9 on her bottom was adequately assessed and incorporated into her comprehensive functional assessment.	W 259		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interviews it was determined the facility failed to ensure an individual was provided with general and preventative medical care for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in an individual experiencing ongoing issues with pain and no pain assessment was completed. The findings include: 1. Individual #1's IPP, dated 5/27/10, documented an 18 year old female diagnosed with profound mental retardation, blindness, hydrocephalus with a ventriculoperitoneal shunt (a surgery performed to relieve intracranial [inside the skull] pressure caused by hydrocephalus [water on the brain]), heavy menses with extreme cramps, and constipation. Individual #1 was non-verbal and had limited expressive communication skills. a. Individual #1's record documented she was diagnosed with Dysmenorrhea (a gynecological medical condition characterized by severe uterine pain during menstruation) and had Physician's Orders for PRN pain medication as follows: - 8/18/10: A Nurse Practitioner note documented "Dysmenorrhea - when current Ibuprofen supp	W 322	**W 322 483.460(a)(3) PHYSICIAN SERVICES** Preferred Community Homes has implemented a Pain Scale to document her pain issues. Preferred Community Homes has assigned a Registered Nurse to support and provide training to the LPN. The RN will monitor nursing records quarterly to verify regulation compliance and be available for the LPN to assist with the needs of the residents. During the quarterly review the RN will be reviewing all records to verify that pain assessments are completed as needed. If there is a time that a resident is experiencing pain and a pain assessment is not being completed, the RN will be responsible to immediately implement a pain scale for the resident. **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/31/10	

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W 322	Continued From page 10 (suppositories) are completed may use Tyl (Tylenol) 650 mg supp q (every) 6 hours prn (as needed)." - 8/20/10: A Nurse's Note, late entry for 8/18/10, documented the Nurse Practitioner "here for rounds - Dysmenorrhea when current Ibuprofen supp (suppositories) are completed may use Tyl (Tylenol) 650 mg supp q (every) 6 hours PRN (as needed)..." Individual #1's 8/10 Physician's Order stated she received Ibuprofen (a nonsteroidal anti-inflammatory drug) 400 mg suppositories every 12 hours for menses discomfort PRN. However, her records did not include any documentation of what overt behavior she displayed when she was experiencing pain/discomfort related to her diagnosis of Dysmenorrhea. The survey team met with the Administrator, contract RN, and the RN from the parent company on 9/15/10 at 5:50 p.m. The contract RN reported no pain assessment had been completed but she just found one on the Internet that needed to be modified for Individual #1. The facility failed to ensure Individual #1's pain/discomfort related to her diagnosis of Dysmenorrhea was adequately assessed to identify the overt behaviors she displayed when she experienced such pain. b. Individual #1's 2010 Menstrual Record documented she had medium flow on 2/25/10 and light flow on 2/24/10 and 8/28/10 - 8/31/10. No other documentation of menstruation was	W 322		

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W 322	Continued From page 11 present. However, her record was reviewed and documented she was receiving pain medication which could not be correlated to her Dysmenorrhea as follows: Individual #1's MAR from 7/1/10 - 9/14/10 documented she received the following: - 7/18/10 at 2:00 (a.m./p.m. not indicated): Ibuprofen 200 mg 2 tablets due to "pain" - not effective. The MAR did not document the overt behavioral indicators Individual #1 displayed to express that she was in pain. - 7/19/10 at 11:30 a.m.: Ibuprofen 200 mg 1 tablet for "pain" - effectiveness not documented. The MAR did not document the overt behavioral indicators Individual #1 displayed to express that she was in pain. - 8/13/10 at 2:30 p.m.: Ibuprofen 400 mg suppository (reason not documented) - not effective. - 8/13/10 at 7:30 (a.m./p.m. not indicated): Ibuprofen suppository (reason and dose not documented) - effectiveness not documented. - 8/28/10 at 11:00 a.m.: Ibuprofen 400 mg suppository (reason not documented) - effective. - 8/29/10 at 9:15 a.m.: Ibuprofen 400 mg suppository (reason not documented) - effectiveness not documented. - 8/30/10 at 2:30 p.m.: Ibuprofen 400 mg suppository for "pain" - effective. The MAR did not document the overt behavioral indicators Individual #1 displayed to express that she was in	W 322		

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W 322	Continued From page 12 pain. - 8/31/10 at 5:30 p.m.: Ibuprofen suppository (reason and dose not documented) - not effective. - 9/5/10 at 4:00 p.m.: Ibuprofen 400 mg suppository was given for "pain" - effective. The MAR did not document the overt behavioral indicators Individual #1 displayed to express that she was in pain. - 9/6/10 at 12:00 p.m.: Ibuprofen 400 mg suppository was given for "pain" - effective. The MAR did not document the overt behavioral indicators Individual #1 displayed to express that she was in pain. The survey team met with the Administrator, contract RN, and the RN from the parent company on 9/15/10 at 5:50 p.m. The contract RN reported no pain assessment had been completed but she just found one on the Internet that needed to be modified for Individual #1. The facility failed to ensure Individual #1's MARs consistently documented the reason, dose, and effectiveness of her PRN pain medications. Further, there was no assessment to identify the overt behaviors she displayed when she experienced such pain. c. Individual #1's record documented other pain related issues, as follows: - 9/2/10: A Nurse Practitioner noted documented "refuses to sit on bottom...seems to hurt with sitting in chair but sits on floor ok." The report showed no skin lesions were found.	W 322		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 13 - 9/10/10: A note from school stated Individual #1's "right [sic] foot/leg appears very painful. She does not want to walk on it or bear weight." The survey team met with the Administrator, contract RN, and the RN from the parent company on 9/15/10 at 5:50 p.m. The contract RN reported no pain assessment had been completed but she just found one on the Internet that needed to be modified for Individual #1. In sum, Individual #1 continued to experience intermittent pain. However, no comprehensive pain assessment was completed. Individual #1 received pain related medications without clear documentation as to the specific reason for pain, dose of medication, and effectiveness of medications. Additionally, no information related to how staff were to identify and address pain issues for Individual #1 could be found. The facility failed to ensure Individual #1 received a pain assessment with consistent monitoring and documentation related to her ongoing intermittent pain issues.	W 322		
W 344	483.460(d)(2) NURSING STAFF The facility must employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure sufficient licensed nursing services were employed and/or arranged to care for 7 of 7	W 344	**W 344 483.460(d)(2) NURSING STAFF** **Currently the work assignment for the LPN has been revised. Previously the LPN was responsible to assist the residents to scheduled appointments. The LPN spent many hours per week helping with the appointments. The work revision includes having the direct care staff assists the individuals to get to their appointments. The LPN may feel**	

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W 344	Continued From page 14 individuals (Individuals #1 - #7) whose health needs were reviewed. This resulted in a lack of sufficient licensed nursing personnel being available to meet the health needs of all individuals assigned to the caseload of the LPN. The findings include: 1. An observation was conducted at the facility on 9/14/10 from 5:00 - 6:25 p.m. During that time, Individual #1 was noted to be seated at the dining table. She was leaning to the right side such that her right hand was positioned on the seat of the chair and her left buttock was not touching the seat. When asked, present staff stated that Individual #1 would not sit flat with both buttocks on the chair. The staff reported that given time, Individual #1 would lean back and "slide" down to where she was sitting on her sacral area (the large triangular bone at the base of the spine) and eventually turn and position herself so that she was bent over the chair with both knees on the floor and her upper body resting on the seat of the chair. When Individual #1 was finished eating, she was prompted to take her dishes to the sink, which she did. It was noted that once at the sink, she grasped the edges of the sink with both hands and lifted her left foot from the floor. When asked during the observation, the LPN stated that given her workload, she did not have time to complete observations. The RN, who was present during the observation as well, stated she did not know Individual #1 as she started at the facility on 8/19/10. The RN reported she was under contract for 20 hours a week which included drive time to and from the facility (approximately 4 hours per round trip), and was still in process of auditing medical charts.	W 344	**like she needs to attend some of the appointments and in this case she can meet them at the appointment or ride with them. In addition, Preferred Community Homes is assigning an RN to work twenty hours per week in the Wendell area to provide oversight and assistance to the LPN. Interviews are scheduled to occur on 10/21/10. The Director of Nursing from the Boise office will continue to provide oversight and direction for the Wendell area.**	

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a. When asked, the LPN stated she was responsible for 23 individuals' health care as follows: Individuals #1 - #7 residing in the facility, six (6) individuals residing in a nearby facility owned and operated by the same company, and ten (10) individuals receiving residential services in a nearby apartment complex, owned and operated by the same company.

Individuals #1 - #7's medical records were reviewed and showed their health and medical needs, as follows:

- Individual #1 was an 18 year old female diagnosed with profound mental retardation, blindness, hydrocephalus with a ventriculoperitoneal shunt (a surgery performed to relieve intracranial [inside the skull] pressure caused by hydrocephalus [water on the brain]), heavy menses with extreme cramps, and constipation.

Her routine medications included Miralax (a laxative drug) 20 cc each evening, Ortho Evra patch (a hormonal drug) one a week, vitamin D (a supplemental drug) 2000 units each day, and Lipitor (a cholesterol drug) 80 mg daily. Additionally, she received Ibuprofen (an anti-inflammatory drug) 400 mg suppositories every 12 hours PRN for menses discomfort and Tylenol (a non-opioid drug) 650 mg every 6 hours PRN for pain.

- Individual #2 was a 35 year old female diagnosed with profound mental retardation, seizure disorder, anorexia, osteopenia, constipation, and hydrocephalus with a ventriculoperitoneal shunt (a surgery performed to

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W 344	Continued From page 16 relieve intracranial [inside the skull] pressure caused by hydrocephalus [water on the brain]). She used a wheelchair for mobility purposes. Her routine medications included Depakote (an anticonvulsant drug) 750 mg BID, Multi-vitamin with calcium each day, Tegretol XR (an anticonvulsant drug) 400 mg each morning, Tegretol 300 mg each evening, Topamax (an anticonvulsant drug) 25 mg BID, Fiber Lax (a laxative drug) BID, Cleocin-T ointment to face BID, Oyster-cal 500 mg 3 tabs daily, Miralax (a laxative drug) 200 cc each morning, and Levothyroxine (a thyroid drug) 0.5 mcg each morning. - Individual #3 was a 35 year old male diagnosed with profound mental retardation, spastic quadriparesis, cerebral palsy, cortical blindness, constipation, osteopenia, and a history of cystic hygroma. He had an intrathecal Baclofen (an antispastic drug) pump, dislocated left hip, and had a complex reconstruction to his upper left arm. He used a wheelchair for mobility purposes. His current medications included: Senokot (a laxative drug) 2 tabs each evening, Vitamin C 500 mg BID, Co-enzyme Q-10 (a supplemental drug) 60 mg each evening, Miralax 20 cc daily, Vitamin D BID, and Calcium 500 mg BID. - Individual #4 was a 35 year old male diagnosed with profound mental retardation, seizure disorder by history, kyphoscoliosis, quadriplegia with profound flexion contractures of both upper and lower extremities, bilateral hip dislocation, cortical blindness, hearing impairment, gastritis, constipation, and osteopenia. He used a wheelchair for mobility purposes.	W 344		

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His routine medications included Ferrous Sulfate (a anti-anemic drug) 325 mg daily, Baclofen 20 mg TID for spasticity, Miralax 30 cc daily, Simplastin (a cholesterol drug) 20 mg daily, Vitamin D 1000 u BID, and Calcium 500 mg BID.

- Individual #5 was a 15 year old male diagnosed with profound mental retardation, tuberous sclerosis, and seizure disorder, hematuria (abnormal bleeding in a person's genitourinary tract), and constipation by history. He wore a protective helmet related to multiple seizures daily.

His routine medications included Keppra (an anticonvulsant drug) 2000 mg BID, Felbatol (an anticonvulsant drug) 600 mg BID, Lactulose (a laxative drug) 30 cc BID, Felbatol 300 mg each afternoon, and Miralax 20 cc daily.

- Individual #6 was a 36 year old male diagnosed with profound mental retardation, arrested hydrocephalus status post prematurity, spastic quadriplegia, severe dorso lumbar scoliosis; seizure disorder, CVA (cerebral vascular accident - also known as a stroke), severe orthopedic deformities of feet, cortical blindness, constipation, left wrist fusion with flexor tendon lengthening, status post left femur fracture and had a Baclofen pump placement. He used a wheelchair for mobility purposes.

His routine medications included Cleocin-T to face BID, Baby oil to ears bilaterally each evening, Benzoyl peroxide 5% to face BID, Lamictal (an anticonvulsant drug) 100 mg BID, Colace (a diuretic drug) 200 mg each evening, Miralax 30 cc each morning, Miacalcin spray (a

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W 344	Continued From page 18 bone density drug) to alternating nostrils daily, and Calcium with Vitamin D 600 mg BID. - Individual #7 was an 18 year old male diagnosed with neonatal hypoxia encephalopathy, profound mental retardation, cerebral palsy, seizure disorder, scoliosis, left hip dislocation with reconstruction, microcephaly, cortical blindness, and spastic quadriparesis. He received his medications and nutrition via a gastric tube and used a wheelchair for mobility. His routine medications included a liquid multi-vitamin daily, Calcium 500 mg BID, Zonegran (an anticonvulsant drug) each evening for seizure control, Baclofen 15 mg TID, and Eucerin cream to face BID. b. When asked during the observation on 9/14/10 from 5:00 - 6:25 p.m., the LPN reported her last 2 week pay period showed she had worked 128.5 hours. The LPN's Job Description was reviewed and showed the following job duties were required of her: - Coordinate health care services on the basis of each individual's needs and administer total nursing care for each individual and ensure all assessments, appointments and evaluations were updated. - Ensure that any individual who had medical procedures completed that required sedation such as gastric tube replacement, dental work, colonoscopies, etc., was put on the 1 to 2 day assessment protocol. During the 2 days post procedure, the individual was to be assessed	W 344		

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W 344	Continued From page 19 after returning to the home, on day 1 post procedure and at nurse's discretion, could be assessed again on day 2. - Implement any medication changes. - Ensure that all individuals were assessed (head-to-toe) upon admission, quarterly, and as needed. - If the caseload included individuals who had gastric tubes, complete specialized monthly assessments to include temperature, oxygen saturation, blood pressure, pulse, respirations, auscultation of lung sounds and bowel tones, assessment of stoma site and surrounding tissue and skin color. - Ensure annual nursing summaries were done in a timely fashion. - Complete rounds to home a minimum of 4 days per week (Monday through Friday) LPN may round at any hour. LPN could opt to round via phone one day of the week to allow one uninterrupted day to work on paperwork in office. The LPN was required to contact each home in the morning via telephone and review recent health status forms (could also be faxed to LPN). Throughout the day, the LPN was to maintain contact with home via phone/fax and was required to do an on-site visit if an assessment of an individual was necessary. - Review Health Status Reports on a daily basis (weekdays) and provide appropriate instructions and follow up. On the day the LPN did not round, LPN could review Health Status reports via phone or fax.	W 344		

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W 344	Continued From page 20 - Review Incident and Accident Reports in a timely fashion and follow-up as necessary. - Attend IPP meetings. - Arrange transportation of individuals to medical appointments. - Was on-call for homes. - Ensure that individuals received annual flu vaccinations and tuberculin tests upon admission. - Flush individuals' ears as needed. - Participate in Interdisciplinary Team meetings. - Notify physician(s) of changes in individuals' condition, medication changes, dietary recommendations, etc. - Client education regarding dietary and health issues. - Order and maintain over-the-counter medication supply as well as medical supplies such as Band-Aids, syringes, gloves, etc. - Maintain medical records on each individual which included documentation on each individual at a minimum of monthly and as needed for change in condition, physician orders, med changes, etc. Ensure emergency information face sheet was current in each individual's book. Ensure physician recapitulation orders were current. Ensure each individual's MAR contained current information. Track and maintain all individual's immunization records and routinely	W 344		

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W 344	Continued From page 21 audit individuals' charts to ensure compliance. - Pharmacy Services: Set up monthly medications for each individual including completing a cycle fill for each individual and faxing to the pharmacy. Communicate with pharmacy for medication changes throughout the month as necessary. - Generate current MARs at the beginning of each month and ensure accuracy. The LPN was required to update MARs as necessary. - Provide staff training including monthly gastric tube classes, infection control education, ensure OSHA compliance, address infection control issues with regular staff in-services, complete Medication Certification observations for all medication passers, and conduct in-services quarterly, and as needed, on topics that need to be addressed. - Oversee Employee Wellness including the administration of tuberculin tests and Hepatitis B vaccinations (series) for all new employees, administer tetanus shots as necessary for employees, assessment of injured employees as necessary, and maintain accurate and current information pertaining to the employee wellness library. - Maintain personal growth including attending continuing education classes as appropriate, attend the annual corporate nursing conference, attend a minimum of 2 classes at the annual health care conference, and maintain membership in Developmental Disabilities Nurse's Association. The Administrator was interviewed on 9/15/10 at	W 344		

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W 344	Continued From page 22 9:00 a.m. When asked, he stated that when he assumed administrator duties on 7/27/10, it was identified that the number of nursing personnel was not adequate. He stated they developed a plan to train the RSCs to assist with medical appointments and to hire an assistant for the LPN. He stated the LPN currently took care of all medical appointments. The Administrator reported many of the medical appointments were not local. He stated a dentist appointment required half a day to complete due to the location of the dentist. Further, he stated they added a 24/7 on-call RN to help relieve the LPN as well. The Administrator stated the plan had not been implemented as of the date of the survey. The full time RN from the parent company was present at the facility on 9/15/10. When asked, the RN stated at 3:35 p.m., the LPN's workload was not realistic. In sum, the LPN was responsible to ensure 23 individuals' health care services met their needs in addition to her regularly assigned job duties. The facility identified a need for additional nursing personnel and developed a plan. However, the plan was not implemented at the time of the survey. The facility failed to ensure sufficient nursing personnel were employed or arranged to meet the health care needs of Individuals #1 - #7.	W 344		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455	**W 455 483.470(l)(1) INFECTION CONTROL** The Director of Nursing from the Boise facilities has been to the Cornerstone home and provided training with the	

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W 455	Continued From page 23 This STANDARD is not met as evidenced by: Based on observation, review of nursing job descriptions, and staff interviews it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. That failure directly impacted 1 of 1 individual (Individual #4) observed making a powdered drink mix at the day program, and had the potential to impact all individuals (Individuals #1 - #7) residing in the facility. This had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include: 1. An observation was conducted at the day program on 9/14/10 from 9:55 - 11:05 a.m. During that time, Individuals #2, #3, and #4 were noted to be present with 2 staff and the RSC-in-training. The staff who worked the day shift at the facility were the same staff that worked at the day program. During the observation, the RSC-in-training stated Individual #4 was not feeling well, had diarrhea the night before, and had vomited twice at the facility prior to being transported to the day program site. The RSC-in-training stated the LPN had been contacted with regards to Individual #4 not feeling well, as had the AQMRP, QMRP and RSC. The RSC-in-training stated the former RSC gave instruction to transport Individual #4 to the day program. When asked why Individual #4 had been sent to the day program site if he was ill, the RSC-in-training stated she did not know.	W 455	**staff in regards to the infection control needs of the individuals. Currently the work assignment for the LPN has been revised. Previously the LPN was responsible to assist the residents to scheduled appointments. The LPN spent many hours per week helping with the appointments. The work revision includes having the direct care staff assists the individuals to get to their appointments. The LPN may feel like she needs to attend some of the appointments and in this case she can meet them at the appointment or ride with them. In addition, Preferred Community Homes is assigning an RN to work twenty hours per week in the Wendell area to provide oversight and assistance to the LPN. Interviews are scheduled to occur on 10/21/10. The Director of Nursing from the Boise office will continue to provide oversight and direction for the Wendell area. With the revisions to the LPN's work assignments and the addition of a 20 hour per week RN the infection control needs of the individuals will be better met. The RN is currently assigned to perform quarterly quality assurance checks to verify compliance.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/31/10	

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W 455	Continued From page 24 At 10:20 a.m., a staff was noted to roll Individual #4's wheelchair up to a table that contained a plastic pitcher filled with water, an electric blender, an adaptive switch, and fruit flavored drink mix. The staff was not observed to wash her hands or assist Individual #4 to wash his hands. Individual #4 was observed to be drooling. The staff used her bare hands to wipe drool from Individual #4's mouth with a paper towel and set the paper towel on the table with the other items. The staff then poured water into the blender, added powdered drink mix, grasped the lid of the blender by touching the inside of the lid, and placed it on the blender. The staff held the adaptive switch and asked Individual #4 to turn the blender on. After the drink mix was blended, the staff set the switch down and poured the mixture from the blender to the plastic water pitcher. Grasping the inside of the pitcher lid with her bare hands, the staff placed the lid on the pitcher and obtained three glasses for Individuals #2, #3, and #4. The staff grasped the glasses by placing her bare fingers on the insides of the glasses. The staff then began to pour the drink mixture into the glasses. At that point, the Surveyor interrupted the staff. When asked what training she had been provided regarding infection control, the staff stated she did not know what that was. When asked how she prevented the spread of germs from one person to another, the staff stated she did not know. The former RSC, who arrived during the observation, stated the staff should have completed handwashing and should not have touched the inside of the glasses or lids.	W 455		

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W 455	Continued From page 25 The facility's job descriptions were reviewed and documented the LPN was responsible for providing staff training including infection control education and addressing infection control issues with regular staff in-services. However, during an observation at the facility on 9/14/10 from 5:00 - 6:25 p.m., the LPN stated that given her workload, she did not have time to complete observations. The facility failed to ensure proper infection control procedures were trained and followed. Repeat Deficiency	W 455		

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PREFERRED COMMUNITY HOMES - CORNER!	2028 EAST 2975 SOUTH WENDELL, ID 83355

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MM209	16.03.11.075.15 Right to Personal Items Right to Personal Items. Each resident admitted to the facility must be permitted to retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, and unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W137.	MM209	**MM209 16.03.11.075.15 RIGHT TO PERSONAL ITEMS** Please refer to the plan of correction given for W137.	
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W259.	MM724	**MM724 16.03.11.270.01(a) ASSESMENTS** Please refer to the plan of correction given for W259.	
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	**MM725 16.03.11.270.01(b) QMRP** Please refer to the plan of correction given for W159.	
MM726	16.03.11.270.01(c) Individual Resident Treatment	MM726		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	C 09/16/2010

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MM726	Continued From page 1 Plan In addition to the participation of the IDT, the individual resident treatment plan will be developed with the participation of: This Rule is not met as evidenced by: Refer to W207.	MM726	**MM726 16.03.11.270.01(c) INDIVIDUAL RESIDENT TREATMENT** Please refer to the plan of correction given for W207.	
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735	**MM735 16.03.11.270.02 HEALTH SERVICES** Please refer to the plan of correction given for W322.	
MM760	16.03.11.270.03 Nursing Services Residents must be provided with nursing services in accordance with their needs. There must be a responsible staff member on duty at all times who is immediately accessible, to whom residents can report injuries, symptoms of illness, and emergencies. The nurse's duties and services include: This Rule is not met as evidenced by: Refer W344.	MM760	**MM 760 16.03.11.270.03 NURSING SERVICES** Please refer to the plan of correction given for W344.	
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio	MM769		

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MM769	Continued From page 2 Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	**MM769 16.03.11.270.03(c)(vi) CONTROL OF COMMUNICABLE DISEASES AND INFECTION** **Please refer to the plan of correction given for W455.**	